PRINTED: 11/29/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES GOVERNMENT OF THE DISTRICT OF COLUMBIA OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) **DEPARIMENTS OF HEALTH** (X3) DATE SURVEY HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR COMPLETED B. WWASHINGTON, D.C. 20002 09G098 11/04/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE MULTI-THERAPEUTIC SERVICES, INC WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE CATE DEFICIENCY W 000 l **INITIAL COMMENTS** W 000 A recertification survey was conducted from November 2, 2009 through November 4, 2009. 55th Survey Responses 12 09 The fundamental survey process was utilized. A random sampling of three clients was selected W104 from a residential population of five females with mental retardation and other disabilities. MTS does have systems and dedicated staff to insure that day program "Pass Through" payments are disseminated to its sister day providers in a timely manner but MTS nor any The survey findings were based on observations other residential provider can unilaterally address pass and interviews in the group home and at two day through payment concerns when they are based on programs, and a review of records, including processing issues at ACS or Health Care Finance. It should unusual incident reports. be noted that MTS has not had similar problems with its W 104 483.410(a)(1) GOVERNING BODY W 104 other sister day providers, only this particular one. The governing body must exercise general policy, Even though the payment problem experienced by the day budget, and operating direction over the facility. provider did not accrue to MTS' failure to properly process payments or disseminate payments received in a timely manner, this day provider decided to suspend the individuals involved thereby denying them active treatment services they need. That act amounts to punishing the This STANDARD is not met as evidenced by: person supported for a payment concern that is beyond Based on observation, interview, and record their control and that of MTS. In such cases, MTS will review, the facility failed to implement an effective advocate for the right of the person to choose another day system to ensure agreements between the day provider who can meet their needs. MTS is currently program provider and the group home was moving in that direction for Client #1 and #2 supported by executed for two of three clients in the sample. DDS...12-30-09 (Clients #1 and #2) As it has in the past, MTS will insure in the future: The finding includes: Day service billings received will be processed in On November 12, 2009 at approximately 8:55 a timely manner by the MTS accounting staff A.M. Client #1 was observed leaving the facility member dedicated to that task; with her peers and direct care staff. At 2:10 p.m., System checks will be completed to track the the client was observed leaving the facility with processing of the billings; Day programs will be notified when payments staff to bring her peers home from the day and remittance information is received; program. Payments will be provided to the day program within 48 hours of receiving the check and Interview with the direct care staff revealed that remittance advice; there was a problem with Client #1's day program

and that she had not attended since the summer. ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

MTS will work with its sister day providers to resolve any pass through payment concerns that develop...12-30-09. TITLE

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

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(X6) DATE

	TMENT OF HEALTH		!				FORM	11/29/2009 APPROVED 0938-0391
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	ROVIDER OR SUPPLIER	CES, INC			9.	REET ADDRESS, CITY, STATE, ZIP CODE		
			<u> </u>			WASHINGTON, DC 20019		
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W 104	Continued From pa	ne 1	1	۱۸/	104			
	During an interview Retardation Profess 2, 2009 at 9:25 a.m 13, 2009 Clients #1 their day program for The QMRP indicate case manager attemprogram to discuss According to the QI group home alleged Interview with the Coase manager reverseadmitted to her discussed in the time of QMRP indicated the had been unsuccessinancial issue with	with the Qualified sional (QMRP) or a., it was revealed and #2 were sustern and #2 were sustern and the and the issue on August that payments was program on Septitude of the survey, how at the group homes full in resolving the day program.	November that on July spended from or services. The clients of the day gust 12, 2009. The tine day program for was eptember 17, wever, the provider Client #1's	VV				
	Interview with the case manager is because of non-pay	revealed the day part #2 returned to 2009. Further interinted that Client eturn to the day part of the day par	rogram the program erview with ant #1 had not					
	A telephone intervie 2:45 P.M. with the a revealed that it was review the service in treatment providers After verification of a should sign them are agency for processi- agency provides writhere are no concer- group home provider.	agency's chief final the policy of the nvoices submitted for accuracy upon the invoices, the nd forward them thing and payment. Itten remittance are, issues a checer to be passed of	provider to d by the day in receipt. provider to the funding The funding divice, and if k to the					

CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO. 0938-0391</u> (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION A. BUILDING B. WING 096698 11/04/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE MULTI-THERAPEUTIC SERVICES, INC WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID. (X5) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) W 104 Continued From page 2 W 104 acknowledged that the agency had experienced intermittent delays in receiving day program payments from the funding agency, which in the past had prevented the agency from sending payments to the day program within timeframe required by the agreement. The chief financial officer, however, indicated that Client #1's day program debt might be partially related to an inadvertent day program book keeping error. The review of the Agreement for the Provision of Active Treatment Services to Residents of Intermediate Care Facilities for Person with Mental Retardation revealed the following information: "If MAA's fiscal intermediary denies any claims submitted by ICF/MR for services provided by Active Treatment Provider for any billing cycle, ICF/MR agrees to provide a copy of the remittance advice to Active Treatment Provider as soon as possible so that Active Treatment Provider is aware of such denials and the reasons for them." Although interview with the QMRP and the residential program director revealed that new day placements was being sought for both Client #1 and #2, there was no evidence that an effective system had been implemented to prevent the alleged untimely payment for day treatment services, which had resulted in the clients' suspension from their day programs. 483.420(d)(2) STAFF TREATMENT OF W 153 W 153 CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported FORM CM\$-2567(02-99) Previous Versions Obsolete

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STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUP IDENTIFICATION	PLIER/CLIA	(X2) ML A. BUIL		NSTRUCTION		COMPLI	URVEY
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	PROVIDER OR SUPPLIER THERAPEUTIC SERVIO	CES, INC			927 55TH	DRESS, CITY, STATE, ZII I STREET, NE IGTON, DC 20019	PCODE		
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W 153	Continued From pa immediately to the a officials in accordar established procedu	administrator or to nce with State law	o other o through	W 1	53				
	This STANDARD is Based on observation review, the facility for missed medication reported to DOH as of the three clients in	tion, staff interview failed to ensure ar at the day progra s required by local	v, and record n incident of a im was law for one	,		·			
	The finding includes Record review on 1 10:30 a.m. revealed (UIR) for missed me #3's habilitation recidated 2/11/2009 fro and it provided infor "omission of medication the day progratic incident report and its	11/3/2009 at approduced an unusual incided colors was file cord. The incident om Client #3's day mation regarding ations. "A memoral was attached to the colors of the col	ent report ed in Client report was program an prandum to this		W153			· 	
	"On 2/11/2009, eigh Program] missed the prescribed medication temporary registered Agency] to administration failed to complete the	nteen individuals a neir 12noon dosag ions/or treatments id nurse assigned ter medication on nis responsibility."	at [Day le of s. The by [Staffing this date		that was the day g and prov what it d assumed to the Su report. In	a case of an incident occ s not detected or reporte program did uncover the vided its investigation red did not know about and that the day program we late Agency as well as p on the future, MTS will in	ed in a timely to issue, it discepted the issue, it discepted the issue of the its insure that it	y manner, isolosed to could not otrectly se the incivestigation	Once MTS report ident n
Further record review revealed on the at approximately 10:40 a.m. revealed was prescribed to receive 10mg of Re (Metoclopramide HCL 5mg/5ml Solut Monday through Friday as written on physician's orders.		, Client #3 eglan ion) at noon the 10/2009		programs State Age It should medicatio caused by not an on QMRP wi	reports and investigations for incidents that occupency the same day that I be noted that no harm on passes and that this by the circumstances that going concern or problem	ons it receives at the day it receives it resulted in the was a single of the day at the permitted the control of the control	es from da program t 12-20-6 he missed occurrence program ar	to the 09. ce nd	

Interview with the qualified mental retardation

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/29/2009 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 09G098 11/04/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE MULTI-THERAPEUTIC SERVICES, INC WASHINGTON, DC 20019 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) W 153 Continued From page 4 W 153 professional (QMRP) on 11/3/2009 at approximately 2:07 p.m. revealed she was notified of the missed medication on 3/9/2009. She was not sure why it took the day program almost a month to notify her of the incident. The QMRP however failed to notify the Department of Health of this medication error as well. W156 W 156 483.420(d)(4) STAFF TREATMENT OF W 156 **CLIENTS** See the responses for W153. In addition, the QMRP did not seek to conduct an investigation at the day program based The results of all investigations must be reported on the described incident. The day program conducted its to the administrator or designated representative own investigation and provided MTS with its or to other officials in accordance with State law report/findings. Residential staff cannot conduct within five working days of the incident. investigations at non-affiliated, sister day programs unless given special permission to do so or the program agrees to a joint investigation. Neither was necessary in this case. This STANDARD is not met as evidenced by: The day program, once it uncovered the incident, Based on observation, staff interview and record investigated and provided its findings. As mentioned in W153, MTS will insure that it passes on such incident review the facility failed to ensure an investigation reports and investigations received from day programs the into an incident of a missed medication at the day day they are received... 12-20-09. program as required by this section for one of three clients in the sample. [Client #3] The finding includes: Record review on 11/3/2009 at approprimately 10:30 a.m. revealed an unusual incident report (UIR) for missed medications was filed in Client #3's habilitation record. The incident report was dated 2/11/2009 from Client #3's day program and it provided information regarding an "omission of medications. " A memorandum from the day program was attached to this incident report and it detailed the following: "On 2/11/2009, eighteen individuals at [Day

Program] missed their 12noon dosage of prescribed medications/or treatments. The temporary registered nurse assigned by [Staffing

PRINTED: 11/29/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 09G098 11/04/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE **MULTI-THERAPEUTIC SERVICES, INC** WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG DEFICIENCY) W 156 Continued From page 5 W 156 Agency] to administer medication on this date failed to complete this responsibility. Further record review revealed on the same day at approximately 10:40 a.m. revealed, Client #3 was prescribed to receive 10mg of Regian (Metoclopramide HCL 5mg/5ml Solution) at noon Monday through Friday as written on the 10/2009 physician's orders Interview with the qualified mental retardation professional (QMRP) on 11/3/2009 at approximately 2:08 p.m. revealed she did not complete an investigation into this incident. As such, the QMRP also failed to provide the Department of Health with her investigative findings as well. W 159 483.430(a) QUALIFIED MENTAL W 159 RETARDATION PROFESSIONAL W159 Each client's active treatment program must be integrated, coordinated and monitored by a MTS has addressed the issues cited under W159 as evidenced by the responses provided for W120, W189, qualified mental retardation professional. W217, W249, W263 and W264. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure the Qualified Mental Retardation Professional (QMRP) coordinated, integrated, and monitored services, for three the three clients in the sample. (Clients #1, #2 and #3)

2. The facility's QMRP falled to ensure that each

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1. The facility's QMRP failed to ensure the coordination of outside services. [See W120]

The findings include:

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PRINTED: 11/29/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED <u>OMB NO. 0938-0391</u> CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING D9G098 11/04/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 927 55TH STREET, NE MULTI-THERAPEUTIC SERVICES, INC WASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) W 159 Continued From page 6 W 159 employee had been provided with adequate training that enables the employee to perform his or her duties effectively. [See W189] 3. The QMRP failed to ensure coordination between the Interdisciplinary team, to include the primary care physician (PCP) in the final decision-making process for determining the most appropriate food consistency for Client #2. [See W217] 4. The facility's QMRP failed to ensure continuous active treatment was implemented in accordance with the interdisciplinary team (IDT) recommendations. [See W249] The facility's QMRP failed to ensure the coordination of services to ensure client's received their medications under informed consent. [See W263] The facility's QMRP failed to ensure restrictive measures were implemented only with the written informed consent of the Human Rights Committee. [See W264] W 217 483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN W 217 The comprehensive functional assessment must include nutritional status. This STANDARD is not met as evidenced by: Based on observation, interview, and record

sample. (Cilent 2).

review, the facility failed to ensure that the comprehensive functional assessment included a thorough evaluation of clients' eating skills to determine the appropriateness of dietary recommendations, for one of three clients in the

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SURPLIED (FIG. 14) (X2) MILL TIPLE CONSTRUCTION (X2) MILL TIPLE (

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W 217	Continued From particles on 11/2/09 at 1:00 independently eath regular consistency. She rapidly ate the verbal prompting freating pace. Intenduring this time cout of feed herself, how prompting to prever prescribed pureed. On 11/2/09 at 4:25 client fed herself a At approximately 6 client fed herself. For Client #2 to eat modular fed herself. For the Speed (SLPs) assessment client was able to the bread-type dessert nutritionist had approximately 3:15 aware of the Speed (SLPs) assessment client was able to the bread-type dessert nutritionist had approximately 3:15. Cake and brownies for sisize).	p.m., Client #2 wang a meal of pure y liquids at her da food requiring in rom the staff her divided with day properties with day properties with day properties of p.m., at her grown snack of pudding 50 p.m. on the staff verballed by the showing the showing of p.m. revealed the chiral pure staff on the chiral pure staff on the chiral pure pattern which indicates of p.m. staff also reported the client the showing buns, so the chiral pure put the client the chiral pure pattern put the client the chiral pure pattern put the client the chiral pure pattern put the client the client the client the chiral pure pattern put the client the c	ed foods and by program. termittently o reduce her tram staff lient was able arbal g her the from a cup. The f	W	217			
	p.m., confirmed the client may have sof brownies. Further r. 3:15 p.m. revealed 7/808, which stated current diet (pureed	e staff statements it cakes like hone ecord review on a SLP Assessme I "Swallow function	that the y buns and 1/3/09 at nt dated					

DEPART	IMENT OF HEALTH	 AND HUMAN S MEDICAID SE	ERVICES		·	PRINTED: 11/29/200 FORM APPROVEI OMB NO. 0938-039	D
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W 217	Continued From pa	age 8		W 2	217 W217		
W 249	for pacing during m stated the client shiftoods, however "ca honey buns, soft co (It is to be given in Review of Client #2 November 2008 re "Can have soft item cookies, and brown in bite size). The redated 10/01/09, how Regular- Low Chole the client. The was nutritionist and/or the proval of the PCI #2 to have bite size to their being docur assessments and red 483.440(d)(1) PRO	nould have pureed an have soft items cookies, and brown bite size)." 2's Mealtime Protected Research Pureed Remails. Cakes, honories for snack (It is review of the physical power, revealed a lesterol Diet" was as no evidence that he SLP had sough Prior to recommendations of procommendations of CRAM IMPLEME	d texture s i.e. cakes, ries for snack cool dated egular Diet. hey buns, soft is to be given scian's orders a "Pureed - prescribed for at the mending Client desserts prior pressional s. ENTATION			er than pureed can be eccialist is aware of the nendation that indicates led. Once the results of and, they will be shared and Nutritionist. The y the diet orders at that 's orders will be changed 30-09.	
5	As soon as the interior formulated a client's each client must restreatment program interventions and seand frequency to surplicatives identified plan. This STANDARD is Based on observation review, the facility fareceive interventions one of three samples.	is Individual programme consisting of nees consisti	am plan, s active ded int number ement of the program enced by: v and record at clients their ISP for		Client #3 completed a number of he during the course of the ISP year an maximum potential on others. On 12 meeting will be held and new object. The new objectives will be implemed in the future, the QMRP will insure "Maxed out" objectives are replaced by completing addendums to the ISF approval 12-20-09. The Daily Activity Schedules for each will be revised to reflect both their in (implementation schedule) and supplementation schedule) and supplementation staff on involving the individuals all daily living tasks as supported by train staff on involving the individual daily living tasks, regardless of their 09. Additionally, the QMRP and Facility active treatment implementation at m	d reached her 2-16-09, an ISP team tives will be approved, ented by12-19-09 that completed or I with new objectives with the team's ch individual supported deasurable objectives orted routines that are supporting completing staff). The QMRP will ds supported in all skill levels12-30- Manager will observe sinimum twice weekly	
ľ	The finding includes	s:	1		(apiece) to insure that measurable ob	jectives and supported	

routines are consistently implemented...12-30-09.

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targeted behaviors.

Psychology assessment dated 12/5/2008 recommended take part in "active engagement daily especially during the nours between 4-6 pm" as a proactive means of preventing Client #3's

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G098	B. WING		11/6	04/2009
	PROVIDER OR SUPPLIER HERAPEUTIC SERVI	CES, INC	927	ET ADDRESS, CITY, STATE, ZIP (7 55TH STREET, NE ASHINGTON, DC 20019		
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W 249	Interview with the q professional (QMR approximately 2:20 above "new goats" The facility failed to implementation of (ualified mental retardation P) on 11/3/2009 at p.m. revealed none of the were being implemented.	W 249			
	11:05 a.m. revealed assessment dated following: a. Continue buildi expressive languag recreational/social in	on 11/3/3009 at approximately it, Client #3's Speech (SLP) 7/7/2008 recommended the ing [the] Client's receptive and e skills through interactions as well as using 1 lient to express herself.				
	monitor significant of programming as ne Interview with the querofassional (QMRF revealed Client #3 of the programming professional the programming p	cessary, Jailfied mental retardation P) on 11/3/2009 at 2:50 p.m. Jid not have a current Jiram in place and an updated				
W 261	program and re-ass the Speech and Lan 483.440(f)(3) PROG CHANGE	illent #3's communication essment as recommended by guage Pathologist (SLP). RAM MONITORING &	W 261			
·	The facility must des	signate and use a specially se or committees consisting				

DEPART	TMENT OF HEALTH	 AND HUMAN S MEDICAID SI	ERVICES				FORM OMB NO.	11/29/2009 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUP IDENTIFICATION	PPLIER/CLIA	A. BUI	ILDIN	IPLE CONSTRUCTION	(X3) DATE SU COMPLE	ETED
		09G	098	B. WIN	4G		11/0	4/2009
• •	PROVIDER OR SUPPLIER THERAPEUTIC SERVI	CES, INC			9:	REET ADDRESS, CITY, STATE, ZIP CODE 027 55TH STREET, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIE Y MUST BE PRECEDE LSC IDENTIFYING INFO	ED BY FULL	ID PREF TAG	= X .	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIETE OFFICIENCY)	DULD BE	(X5) COMPLETION DATE
W 261	Continued From participations of members of facing guardians, clients (persons who have contemporary practicent behavior, and controlling interest. This STANDARD Based on observation the Human Rights facility failed to ensure ownership or controlling include. The finding include.	ility staff, parents, (as appropriate), or either experience circes to change in d persons with not in the facility. Is not met as evication, interview, and Committee (HRC) sure that persons rolling interest in the pated on this compluded in the sample.	dualified a or training in inappropriate o ownership or denced by: ind review of c) minutes, the with no the facility militee for two	W	261	W261 The Executive Director of the program MTS non-affiliated members of the Hu Committee attend/participate in all mee by the signature sheets and minutes It	ıman Rights etings as evide	
W 263	On 11/3/09, at 10:: Qualified Mental Re- revealed that the fal- committee had revi- (behavior interventi- medications) for Cli- on 12/19/08. On 1: the HRC minutes di- during which the cli- were discussed rev- individuals with no of- facility. Interview wi- attendees on that di- agency. Further intervealed that no indi- interest in the facility 483.440(f)(3)(ii) PRI- CHANGE The committee shore	tetardation Professacility's specially of the restriction techniques and lients #1 and #2 at 1/4/09 at 3:06 pm dated 12/08 for the lients behavior sujurealed no signature controlling interestith the QMRP revision with the QMRP revision with the Qdividuals without of the date of the lients behavior sujurealed no signature controlling interestith the QMRP revision with the Qdividuals without of the lients behavior and lients without of the lients lients with lients without of the lients with lients wit	esional constituted tive measures rid/or at a meeting nM., review of the meeting ipport plan ties (s) of st in the coaled that all tied by the DMRP controlling meeting. ORING &	W 2	263	W263 The guardian of Client #3 was provide risks/benefits discussion of the psych before agreeing to approve it by signing the consent form will be modified to effects of the medication(s) and the matter guardian will be usked to sign the 30-09. This modified form will be used univerthereafter12-30-09.	notropic drug r ing the consent list the potent nedication itset modified form	nt form. Itial side

DEPARTMENT	OF HEALTH	AND HUMAN S	ERVICES			· 	FORM AI	PPROVED 938-0391
CENTERS FOR STATEMENT OF DEFI AND PLAN OF CORRE	CIENCIES	(X1) PROVIDER/SUF	PLIER/CLIA	(X2) M A. BUI		LE GONG METAL	(X3) DATE SUR COMPLETE	VEY ED
		09G	098	B. WII	/G _		11/04/	2009
NAME OF PROVIDER		CES, INC			9:	REET ADDRESS, CITY, STATE, ZIP CODE 27 55TH STREET, NE VASHINGTON, DC 20019		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIE MUST BE PRECEDE SCIDENTIFYING INFO	D BY FULL	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
This s Based facility medic inform of thre The fi Observed psych of Te the 10 at ap was a (Clore	STANDARD of the clier of the cl	with the written at, parents (if the rdian. Is not met as eview and staff in the sure clients psych a was implement of a client 's guathe sample. [Clients: It morning of 11/2 was administered cations, which in the pulsive behavior clian's orders the 1:35 p.m. revealed 75mg of Anafrich) every evening	denced by: terview, the totropic ted with the rdian for one at #3] 22009 ed a regimen of cluded 300mg r. A review of following day ed this client	W	263			
Treat was s 3/18/ medi the "c as we indicathe u the c form. Then	tment with Ps signed by Clie 2009. The conceptions Client common side ell. In additionate if she "con se of the psycheck boxes be heck boxes be e was no evident of the conception.	iew revealed a "(ychotropic Medic ent #3's medical onesent form did r t #3 was receivin effects" of those n, the medical gu sented" or "did r chotropic medical eing left blank of lence on file to s provided proper	cation" form guardian on not list the g nor did it list e medications pardian did not not consent" for itions due to n the consent ubstantiate the information on					

PRINTED: 11/29/2009

DEPAR CENTE	TMENT OF HEALTH RS FOR MEDICARE	I AND HUMAN SE & MEDICAID SE	ERVICES RVICES			FORM): 11/29/200 1 APPROVE
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUFF	PLIER/CLIA	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE (
		09G	98	B. WING _		4411	14/2000
	PROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CO		04/2009
MULTI-T	HERAPEUTIC SERVI	CES, INC			27 55TH STREET, NE VASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FURTHER REGULATORY OR LSC IDENTIFYING INFORMATION 1/2004 Continued From page 14 revealed there was no evidence the door a were reviewed and or assessed dating back 1/2009 of this year. It was not clear why the alarms were still active despite not having approval from the HRC to continue implementation.		RY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
Who hand	revealed there was were reviewed and 1/2009 of this year, alarms were still ac approval from the H them.	no evidence the control of assessed dating the last two despites not have the continue in the last to	g back to why the wing any aplementing	W 264			
W 322	483.460(a)(3) PHYS	SICIAN SERVICE	S	W 322			
	The facility must pro general medical car	e .			W322 Client #2 received hematology fol (Copy attached) Client #1 had a Prolactin level do attached)9-26-09.	•	
t t t t t t t t t t t t t t t t t t t	This STANDARD is Based on observation review, the facility fathealth services were completion of recomprocedures for two of (Clients #1 and #2). The finding includes: 1. The facility failed the received a hematology on 11/2/09 at 8:02 at the revealed the clie of prevent a low iron to 1/3/09 at 9:05 a.m. of physician's order to 35 mg) tab TID on Mill on Saturday and sterview with the primal 1:00 a.m. revealed the object of the revealed the primal 1:00 a.m. revealed the object of the review with the primal 1:00 a.m. revealed the object of the review with the primal 1:00 a.m. revealed the object of the review with the primal 1:00 a.m. revealed the object of the review of the revealed the review of the review	illed to ensure prediction of three clients in the ensure that the ensure th	ecord ventive ne ne ic ne sample. nt #2 escribed. observed tablet. ing this edication fication on client had sulfate 325 day and ia.		The level was high and the PCP wi indicated that the current level is no begins lactating12-14-09. The new RN will insure that all me in a timely manner by using MTS s all needed follow up in a person-sp 09. In addition, the RN, QMRP and Famonthly to review medical follow u assure all are addressed12-20-09 Finally, the LPN support office will assuring that medical consultations and implemented in a timely manner.	dical follow up or tandard forms to ecific manner! cility Manager me up concerns and to assist the RN in	she cours track 2-30- eet
		Record review rev	ealed a				
I CMS-2567(02-99) Previous Versions Obs	olate Ev	ent ID: C74R11	Facility	ID: 09G098 If cont	inuation sheet Pag	15 at 22
		1				· · · · · · · · · · · · · · · · · · ·	90 IJ DI

PRINTED: 11/29/2009

PRINTED: 11/29/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED <u>OMB NO. 0938-0391</u> CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G098 11/04/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE MULTI-THERAPEUTIC SERVICES. INC WASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ΙĎ PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) W 322 Continued From page 15 W 322 hematology consultation report dated 6/23/08 in which it was noted the client had a diagnosis of microcytosis and should return to the hematology clinic in one year for follow-up. At the time of the survey, there was no evidence that the one year follow-up appointment had been completed for the client. 2. The facility failed to ensure the pharmacist's recommendation that Client #1's Prolactin be monitored every six months was addressed as evidenced below: On 11/2/09 at 8:30 a.m., Client #1 was observed being administered Haldol 5 mg tab (3 tabs, 15 mg). The client laid on the floor and attempted to bang her head as the nurse verbally prompted her to get up from the floor. Interview with the medication nurse revealed the Haldol was prescribed to manage the client's psychosis. Subsequent record review on 11/2/09 at 9:07 a.m. revealed a current physician's order, with an original date of 7/7/08 for Haloperidol 5 mg tab. 15 mg by mouth twice daily in the morning and evening for psychosis. Record review on 11/4/09 at 9:17 aim, revealed a 5/11/09 Quarterly Pharmacy Review which stated "Haldor - Needs Prolactin Q 6 months." The review of the client's Quarterly Pharmacy

FORM CMS-2567(02-99) Previous Versions Obsolete

available.

Reviews dated 11/25/08, 2/25/09, and 8/6/09 revealed assessment of the Client's prolactin level was also recommended at those times. Continued record review however revealed no laboratory reports of prolactin level were

Interview with the primary R.N. on 11/4/09 at 9:30 a.m. revealed that no laboratory tests had

Event ID: C74R11

Facility ID: 09G098

If continuation sheet Page 16 of 22

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 09G098 11/04/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 927 65TH STREET, NE **MULTI-THERAPEUTIC SERVICES, INC** WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) W 322 Continued From page 16 W 322 been conducted to assess Prolactin values. W 331 483.460(c) NURSING SERVICES W 331 W331 The facility must provide clients with nursing services in accordance with their needs. The cited lab work for Clients #2 will be scheduled by...12-20-09. Results will be forwarded to the RN and PCP immediately. This STANDARD is not met as evidenced by: In the future, the RN will use the prescribed, person-Based on observation, interview, and record specific tracking formats to insure that all lab work is verification, the facility's nursing services failed to completed as prescribed by the PCP and ISP...12-30-09. ensure each resident received laboratory In addition, the QMRP will audit the medical records assessments as recommended and prescribed monthly to support the RN...12-30-09. for two of the three clients in the sample. (Clients # 1 and #2) The findings include: 1. On 11/2/09 at 8:02 a.m., Client #2 was administered Ferrous Sulfate 325 (65 mg) tablet. Interview with the medication nurse during this time revealed the client received the medication to prevent a low iron level. Record verification on 11/2/09 at 9:05 a.m. confirmed that the client had a physician's order for Ferrous Sulfate 325 (65 mg) tab TID on Monday through Friday and BID on Saturday and Sundays for anemia. Record review on 11/3/09 revealed a physician's ordered dated 5/11/09 prescribing CBC lab test every three months lipid test every six months to monitor the client. Further review of the client's medical record on 11/3/09 at 11:35 AM, revealed the following laboratory results: CBC: 12/22/08 (12.2 gm.) and 11/26/09 (13.1

gm.)

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PRINTED: 11/29/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G098 11/04/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE MULTI-THERAPEUTIC SERVICES, INC. WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (XS) COMPLETION DATE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 331 Continued From page 17 W 331 During a follow-up interview on 11/4/09 at 1:11 p.m., the primary R.N. acknowledged that no additional CBC values were available. There was no evidence the facility had ensured that the client's laboratory assessments had been conducted at the frequency prescribed by the primary care physician. 2. On 11/2/09, at 4:24 p.m. Client #2 was observed eating a snack of pudding. Interview with the staff indicated the client was prescribed a low cholesterol pureed diet. On 11/3/09 at 9:17 a.m., the review of physician ' s orders dated 10/1/09 for Client #2 revealed she was prescribed a Pureed-Regular-Low cholesterol diet. Further record review revealed a physician's ordered dated 5/11/09 prescribing that a lipid panel be conducted every six months. Available lipid panel results in the client's record were dated 12/22/08 and 3/10/09. During a follow-up interview on 11/4/09 at 1:11 p.m., the primary R.N. acknowledged that no additional lipid report values were available for the client. There was no evidence the facility had ensure that the client's lipid panels were conducted at the frequency prescribed by the primary care physician.

physician.

W 336

3. [Cross refer to W322.2] The facility's nursing services failed to coordinate the pharmacist's recommendation for monitoring of Client #1's serum prolactin level with the primary care

Nursing services must include, for those clients certified as not needing a medical care plan, a

483.460(c)(3)(iii) NURSING SERVICES

W 336

PRINTED: 11/29/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 090098 11/04/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 927 66TH STREET, NE **MULTI-THERAPEUTIC SERVICES, INC** WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PROVIDER'S PLAN OF CORRECTION in (X5) COMPLETION PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) W 336 Continued From page 18 W 336 review of their health status which must be on a W336 quarterly or more frequent basis depending on client need. As indicated by the surveyor, a gap in completing quarterly nursing physicals was created by the departure of one RN and the time it took to replace her. Quarterly nursing This STANDARD is not met as evidenced by: physicals are current for each person supported at this time. In the future, the Director of Nursing will insure that no Based on interview and record review, the facility such gap occurs by assigning another RN to complete the failed to ensure that each client received a task, using consultants in the absence of a permanent RN or physical examination by a Registered Nurse at by completing the task herself...12-30-09. least quarterly, for two of the three clients in the sample. (Clients #1 and #2) The findings include: Interview with the primary R.N. on 1/1/3/09 at 4:40 p.m. revealed that she began working at the group home on 8/13/09. Further interview with the R.N. revealed at that time she began a review of all client's records to determine the status of assessments and appointments/consultations. On 11/4/09 at 9:22 a.m., and 11:29 a.m. respectively, review of Medical records of Clients #2 and #1 revealed that a six-month period had elapsed between quarterly nursing assessments as follows: a. Client #2 had a 2nd quarterly assessment on 4/3/09, then the next nursing quarterly was

conducted on 10/7/09, 5 months later.

b. Client #1 had a 2nd quarterly assessment on 4/9/09, then next nursing quarterly assessment was conducted on 9/28/09, 5 months later.

The R.N. acknowledged that there had been a break between the time the previous primary R.N. was transferred from the facility and the time that she began working at the facility. There was no

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/29/2009 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		09G098	B. WIN	IG		11/0	04/2009
	ROVIDER OR SUPPLIER HERAPEUTIC SERVIO	CES, INC		92	EET ADDRESS, CITY, STATE, ZIP CODE 27 55TH STREET, NE (ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 336	evidence that the facilient received a ph quarterly. 483.460(e)(3) DEN The facility must prothe maintenance of This STANDARD is Based on interview failed to ensure effective and the control of the cont	recility had ensure that each sysical assessment at least TAL SERVICES ovide education and training in oral health. It is not met as evidenced by: and record review, the facility ective education and training in sective education and training in	w a		W350 All staff will receive oral hygiene train with emphasis put on supporting indivitooth brushing 12-30-09. It should be noted that Client #1 present around oral hygiene and dental care be staff support and the dentist when she is	iduals with particular is specific is secure the reserved and the reserved	roper ssues
	of the three clients in #2) The findings include 1. The facility failed the clients as recompliants dental hygier interview with the start revealed the clients activities of daily living interview with the Quarter will be good to assist the QMRP, however, instructed to assist the three times daily toothbrushing in the QMRP had instructed to assist the QMRP had instructed to a single quarter the quarter than th	good dental hygiene for two in the sample. (Clients #1 and it to ensure training to staff and imended to improve the ne. aff on 11/2/09 at 3:37 p.m. required assistance in all ng, including tooth brushing, ialified Mental Retardation i) revealed that the clients did ing objectives to enhance ishing. Further interview with revealed that staff had been ne client's in brushing their ly and to document the			The dentist is successful in treating her and staff incurs similar issues when sur tooth brushing. The QMRP will consult specialist to determine if a protocol swill help staff be more successful in sur during tooth brushing. If it is determine help, the behavior specialist will develon the prescribed techniques12-30-09	despite the topporting her of the topporting her of the developed pporting Clies of that a protect it and train of the train of train of the train of train	oehavior during havior ed that ent #1

		AND HUMAN SERVICES & MEDICAID SERVICES						APPROVED 0938-0391
STATEMENT	OF DEFICIENCIÉS F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	•	NSTRUCTION		(X3) DATE SU COMPLE	
	;	09G098	B. WING	<u> </u>			11/04	4/2009
	ROVIDER OR SUPPLIER HERAPEUTIC SERVI	CES, INC	S	927 55T	DRESS, CITY, STATE, ZIP C H STREET, NE NGTON, DC 20019	;QDE	•	
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W 350	on dental hygione. Further interview wat 12:15 p.m., reve Clients #1 and #2 v. 2. The review of de Client #1 and #2 rebeen identified durievidenced below: a. On 11/4/09 at 9: consultation report large amount of plamaterial alba was pelient received a geand polishing on 1/times daily was received and calculure turn to the dental which she received no evidence, howe procedures implement the rapid a calculus on the clients.	ith the primary R.N. on 11/3/09 aled that the dental visits for vere current. Intal consultation reports for vealed poor oral hygiene hading dental assessments as 39 a.m., Client #1 dental dated 11/26/08 revealed a aque and calculus, and that present on tooth surfaces. The eneral scaling with prophylaxis 27/09. Brushing two to three commended. On 5/18/09, the agnosed with large deposits of s. She was recommended to clinic for a full mouth scaling, I on July 28, 2009. There was ver, that the toothbrushing nented had been adequate to ccumulation of plaque and ent's teeth.	W 35	50				
	revealed that Clien on 11/26/08. The fi plaque, calculus, at teeth surfaces. Poot the client returned scaling prophylaxis Brushing two to the recommended. Du on 5/18/09, the clien	n 11/4/09 at 12:12 p.m., t #2 had a dental consultation nding was "large amount nd material alba present on or oral hygiene." On 1/27/09, to the dentist for generalized and polishing of teeth, ee times daily was uring a follow-up appointment nt was again diagnosed with						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 11/29/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G098 11/04/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **927 55TH STREET, NE MULTI-THERAPEUTIC SERVICES. INC** WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X4) ID (XS) COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCEO TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) W 350 Continued From page 21 W 350 time of the survey, there was no evidence evidence that the facility had implemented an effective brushing program to improve the client's dental hygiene. W 368 483.460(k)(1) DRUG ADMINISTRATION W 368 The system for drug administration must assure W368 that all drugs are administered in compliance with the physician's orders. Interviews with medication nurses indicate that the treatment was given but not properly documented (Hydrogen Peroxide to ears). The RN will train medication This STANDARD is not met as evidenced by: passing nursing to insure that they document all Based on interview and record review, the facility medications and treatments consistently...12-30-09. failed to ensure that medication was administered Additionally, the RN will audit the MARs at minimum weekly to insure the above...12-30-09. without error for one of three clients in the sample. (Client #2) The finding includes: Interview with the primary R.N. on 11/3/09 at 2:18 p.m. revealed that Client #2's treatment prescribed to prevent ear wax impaction was changed by the primary care physician in July 2009. Record review on 11/3/09 at 4:49 p.m. revealed a physician's order dated 7/21/09 for H2O2 (Hydrogen Peroxide) + Mineral Oil 1/2/ + 1/2 in dropper bottle, 3 gtt to each ear 3 x a month each ear. The review of the medication

administration record, however, revealed no documentation that the peroxide (H2O2) + mineral oil drops had not been administered to the client on any day in July 2009. There was no

evidence the facility ensured the client's medication was administered without error.

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING HFD03-0236 11/04/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 927 55TH STREET, NE **MULTI-THERAPEUTIC SERVICES, INC** WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 1000 INITIAL COMMENTS 1000 A re-licensure survey was conducted from November 2, 2009 through November 4, 2009, A random sampling of three residents was selected from a residential population of five females with mental retardation and other disabilities. The survey findings were based on observations and interviews in the group home and at two day programs, and a review of records, including unusual incident reports. 1 183 3508.4 ADMINISTRATIVE SUPPORT l 183 Each GHMRP shall have a Residence Director Chapter 35 who meets the requirements of § 3509.1 and who shall manage the GHMRP in accordance with 3508.4 approved policies and this chapter. This Statute is not met as evidenced by: MTS has addressed the issues cited under W159 as Based on observation, staff interview, and record evidenced by the responses provided for W120, W189, review, the Group Home for the Mentally W217, W249, W263 and W264 Retarded Person (GHMRP) falled to ensure the Qualified Mental Retardation Professional (QMRP) coordinated, integrated and monitored services, for three the three residents in the sample. (Residents #1, #2 and #3) The findings include: 1. The GHMRP's QMRP failed to ensure the coordination of outside services. [See Federal **Deficiency Report Citation W120**] 2. The GHMRP's QMRP failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively. [See Federal Deficiency Report Citation W1891 Health Regulation Administration TITLE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE STATE FORM

Health Regulation Administration

(X8) DATE

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILDE B. WING		(X3) DATE SURVEY COMPLETED	
		HFD03-0236				11/0	4/2009
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1 224	between the interdiprimary care physic decision-making properties of the second properties of th	ed to ensure coordinesciplinary team, to inscian (PCP) in the financess for determining od consistency for Reficiency Report Cital Campber of the Period of the Humber of the Period of the Humber of the Period of the Humber of the Period of	clude the all gothe Resident ation ation are nented in arm (IDT) ency are the ent's ed art Citation are only with an Rights port	1 183	3510.5(a) Staff receives overview of MR to The QMRP will schedule training address this training area and all tags in this survey. The trainings 20-09. And will be completed by 12-30. Additionally, the QMRP will destaff training schedule that covers will repeat that activity for the se 15-10. MTS in also reorganizing both its and its annual training calendars mandates and will implement a 20 the DDS mandates in 20101-30	raining during orient g sessions for staff to others cited in other will be scheduled be-09. The color of the staff of 2 s all required training conditions to reflect the new Disconduction to t	010 gs and r1-
1 224	restrictive measures were implemented only with the written informed consent of the Human Rights Committee. [See Federal Deficiency Report Citation W264] 4 3510.5(a) STAFF TRAINING Each training program shall include, but not be limited to, the following: (a) Overview of mental retardation including, but not limited to, definition, causes of mental retardation, and frequently used medications, the history of care of individuals with mental retardation, and daily living skills; This Statute is not met as evidenced by: Based on record review, the Group Home for the			1 224	ags in this survey. The trainings 20-09. And will be completed by 12-30. Additionally, the QMRP will devistaff training schedule that cover will repeat that activity for the se 15-10. MTS in also reorganizing both its and its annual training calendars mandates and will implement a 20	will be scheduled b -09. sciop a first half of 2 s all required trainin coud half of the yea. s initial orientation u to reflect the new Di 010 schedule that	y i 010 gs ar r 1- rainin

Health Regulation Administration

PRINTED: 11/29/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G098 11/04/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE MULTI-THERAPEUTIC SERVICES, INC WASHINGTON, DC 20019 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) W 263 Continued From page 13 W 263 psychotropic regimen. W 264 483,440(f)(3)(iii) PROGRAM MONITORING & W 264 W264 CHANGE The alarm system was reviewed by the HRC and approved The committee should review, monitor and make based on the elopement issue (See: attached copies)...12suggestions to the facility about its practices and 20-09 programs as they relate to drug usage, physical The issue will be revised 1-29-10. restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure the use of a door alarm was reviewed and or monitored for relevancy for three of five clients residing in the facility. [Clients #3, #4, and #5] The finding includes: As the Residential Director provided the survey team a walk-thru of the home on the morning of 11/3/2009 at approximately 10:00 a.m., door alarms were observed on the rear doors of Client #3 and #4's bedrooms. The RD opened the rear doors in these bedrooms and confirmed that the door alarms were active. Further interview with the RD revealed the door alarms were put in place due to Client #5's history of eldpements.

facility.

The RD also stated that it had been over a year since Client #5 has attempted to elope from the

Review of the Human Rights Committee meeting notes on 11/3/2009 at approximately 3:10 p.m.

Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING 11/04/2009 HFD03-0236 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 927 55TH STREET. NE MULTI-THERAPEUTIC SERVICES, INC WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES PROMDER'S PLAN OF CORRECTION (X4) ID PREFIX COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1224 Continued From page 2 1224 All staff will receive oral hygiene training from the RN Mentally Retarded Person (GHMRP) failed to with emphasis put on supporting individuals with proper ensure training was provided to seven of thirteen tooth brushing...12-30-09 staff in the area of Mental Retardation, (Staff #1, It should be noted that Client #1 presents specific issues #3, #5, #7, #9, #11 and #12) around oral hygiene and dental care because she resists staff support and the dentist when she receives treatments. The dentist is successful in treating her despite the behavior The finding includes: and staff incurs similar issues when supporting her during tooth brushing. The QMRP will consult with the behavior Interview with the QMRP and review of the staff specialist to determine if a protocol can be developed that training records on 11/4/2009 at approximately will help staff be more successful in supporting Client #1 12:30 p.m. verified seven out of thirteen staff during tooth brushing. If it is determined that a protocol can failed to receive training to cover an overview of help, the behavior specialist will develop it and train staff mental retardation. on the prescribed techniques...12-30-09. 1 226 3510.5(c) STAFF TRAINING 1226 Each training program shall include, but not be limited to the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on record review, the Group Home for the Mentally Retarded Person (GHMRP) failed to ensure training was provided to nine of thirteen staff in the area of Infection Control. (#1, #3, #5, #7, #8, #9, #10, #11 and #12) The finding includes: Interview with the QMRP and review of the staff training records on 11/4/2009 at approximately 12:40 p.m. verified nine out of thirteen staff failed to receive training in the management of infection control. 1 228 3510.5(e) STAFF TRAINING 3510.5(e) 1228 See responses for 3510.5(a) above. Each training program shall include, but not be

Health Regulation Administration

Health Regulation Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING HFD03-0236 11/04/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE **MULTI-THERAPEUTIC SERVICES, INC** WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) 1229 Continued From page 4 1229 training records on 11/4/2009 at approximately 1:00 p.m. verified six out of thirteen staff failed to receive training in behavior management. 1232 3510.5(i) STAFF TRAINING 1232 Each training program shall include, but not be limited to, the following: (i) Training of the residents in the maintenance of oral health and hygiene. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP (Group Home for Mentally Retarded Persons) failed to ensure effective education and training in the maintenance of good dental hygiene for two of the three residents in the sample. (Residents #1 and #2) The findings include: 1. The GHMRP failed to ensure training to staff and the residents as recommended to improve the residents' dental hygiene. The facility failed to ensure training to staff and the Residents as recommended to improve the Residents' dental hygiene. Interview with the staff on 11/2/09 at 3:37 p.m. revealed the Residents required assistance in all activities of daily living, including tooth brushing. Interview with the Qualified Mental Retardation Professional (QMRP) revealed that the Residents did not have formal training objectives to enhance their skills in toothbrushing. Further interview with the QMRP, however, revealed that staff had been instructed to assist the Resident's in brushing their teeth three times daily and to

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-0236 11/04/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE MULTI-THERAPEUTIC SERVICES, INC WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1232 Continued From page 5 1232 document the toothbrushing in the Residents' record. Record review 11/4/09 at 4:00 p.m. verified that the QMRP had instructed the staff during a meeting on 1/9/09, to brush the Residents' teeth 3 times daily, however, all staff had not been present at the meeting. Subsequently, there was no evidence that each staff had been trained on dental hygiene. Further interview with the primary R.N. on 11/3/09 at 12:15 p.m., revealed that the dental visits for Residents #1 and #2 were current. 2. The review of dental consultation reports for Resident #1 and #2 revealed poor oral hygiene had been identified during dental assessments as evidenced below: a. On 11/4/09 at 9:39 a.m., Resident #1 dental consultation report dated 11/26/08 revealed a large amount of plaque and calculus, and that material alba was present on tooth surfaces. The Resident received a general scaling with prophylaxis and polishing on 1/27/09. Brushing two to three times daily was recommended. On 5/18/09, the Resident was again diagnosed with large deposits of plaque and calculus. She was recommended to return to the dental clinic for a full mouth scaling, which she received on July 28, 2009. There was no evidence, however, that the toothbrushing procedures implemented had been adequate to prevent the rapid accumulation of plaque and calculus on the Resident's teeth, b. Record review on 11/4/09 at 12:12 p.m., revealed that Resident #2 had a dental consultation on 11/26/08. The finding was "large amount plaque, calculus, and material alba Health Regulation Administration

Health Regulation Administration

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(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER. A. BUILDING B. WING HFD03-0236 11/04/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 927 55TH STREET, NE MULTI-THERAPEUTIC SERVICES, INC WASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DAYE TAG TAG DEFICIENCY) 1232 Continued From page 6 1232 present on teeth surfaces. Poor oral hygiene." On 1/27/09, the Resident returned to the dentist for generalized scaling prophylaxis and polishing of teeth. Brushing two to three times daily was recommended. During a follow-up appointment on 5/18/09, the Resident was again diagnosed with moderate deposits of plaque and calculus. At the time of the survey, there was no evidence evidence that the facility had implemented an effective brushing program to improve the Resident's dental hygiene. 1375 3519.6 EMERGENCIES 1375 Each GHMRP shall document each emergency and enter the follow-up actions into the resident ' s permanent record, which shall be made available for review by authorized individuals. This Statute is not met as evidenced by: Based on staff interview and record review the Group Home for the Mentally Retarded Person (GHMRP) failed to document the follow-up actions for an incident of a missed medication at the day program as required by this section for one of three residents in the sample. [Resident #31 The findings include: 1. Record review on 11/3/2009 at approximately 10:30 a.m. revealed an unusual incident report (UIR) for missed medications was filed in Resident #3's habilitation record. The incident report was dated 2/11/2009 from Resident #3's day program and it provided information regarding an "omission of medications". A memorandum from the day program dated 3/6/2009 verified and substantiated the findings. This memo was attached to this incident report Health Regulation Administration

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION (DENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-0236 11/04/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE MULTI-THERAPEUTIC SERVICES, INC WASHINGTON, DC 20019 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) 1375 Continued From page 7 1375 and it detailed the following: "During an internal review/investigation of the medication protocol for [Day Program], a medication omission error was discovered by [Day Program] Incident Manager. On Wednesday, 2/11/2009, [Day Program] employed a temp nurse via [Staffing Agency] who failed to administer medications to [Resident #3] on this date. We apologize for the delay in notification; however, upon becoming aware of this omission we felt it imperative to inform you." Further record review revealed on the same day at approximately 10:40 a.m. revealed, Resident #3 was prescribed to receive 10mg of Reglan (Metoclopramide HCL 5mg/5ml Solution) at noon Monday through Friday as written on the 10/2009 physician's orders. interview with the qualified mental retardation professional (QMRP) on 11/3/2009 at approximately 2:09 p.m. revealed the information was substantiated, but there was no supporting evidence presented during the survey to substantiate the actions the GHMRP took to address the problem. Record review on 11/3/2009 at approximately 10:30 a.m. revealed an unusual incident report (UIR) for missed medications was filed in Resident #3's habilitation record. The incident report was dated 2/11/2009 from Resident #3's day program and it provided information regarding an "omission of medications". A memorandum from the day program was attached to this incident report and it detailed the following: Health Regulation Administration STATE FORM

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l 375	Continued From pa	ige 8		1 375	3519.6			
	"On 2/11/2009, eighteen individuals at [Day Program] missed their 12noon dosage of prescribed medications/or treatments. The temporary registered nurse assigned by [Staffing Agency] to administer medication on this date failed to complete this responsibility." Further record review revealed on the same day at approximately 10:40 a.m. revealed, Resident #3 was prescribed to receive 10mg of Regian (Metoclopramide HCL 5mg/5ml Solution) at noon Monday through Friday as written on the 10/2009 physician's orders. Interview with the qualified mental retardation professional (QMRP) on 11/3/2009 at approximately 2:08 p.m. revealed she did not complete an Investigation into this neglectful situation. As such, the QMRP also failed to provide the Department of Health with her investigative findings as well. 3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident 's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be foliowed up by written notification within twenty-four (24) hours or the next work day.		of The The (Staffing s date ame day Resident Regian n) at noon e 10/2009 dation	that was not detected or reported in a timely manner. Once the day program did uncover the issue, it disclosed to MTS and provided its investigation report. MTS could not report what it did not know about and perhaps incorrectly assumed that the day program would disclose the incident to the State Agency as well as provide its investigation report. In the future, MTS well investigation				
			nt of other tially are, living way tion shall shall be	1 379	See the responses for W153. In some seek to conduct an investigation based on the described incident. conducted its own investigation a report/findings. Residential sraff convestigations at non-affiliated, singiven special permission to do so a joint investigation. Neither was The day program, once it uncover investigated and provided its findiw W153, MTS will insure that it pass reports and investigations received day they are received 12-20-09.	ion at the day i he day progra ind provided h cannot conduct ster day progra or the prograi necessary in t ed the incident ings. As ment ises on such ir if from day no	program am ATS with its et ams unless m agrees to his case. at, ioned in	
	This Statute Is not n Based on staff interv Group Home for the	iew and record revie	w the					

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Health Regulation Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING HFD03-0236 11/04/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE MULTI-THERAPEUTIC SERVICES, INC WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PRÓVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Continued From page 9 1379 (GHMRP) failed to ensure an incident of a missed medication at the day program was reported to DOH as required for one of three residents in the sample. [Resident #3] The finding includes: Record review on 11/3/2009 at approximately 10:30 a.m. revealed an unusual incident report (UIR) for missed medications was filed in Resident #3's habilitation record. The incident report was dated 2/11/2009 from Resident #3's day program and it provided information regarding an "omission of medications". A memorandum from the day program was attached to this incident report and it detailed the following: "On 2/11/2009, eighteen individuals at [Day Program] missed their 12noon dosage of prescribed medications/or treatments. The temporary registered nurse assigned by [Staffing Agency] to administer medication on this date failed to complete this responsibility." Further record review revealed on the same day at approximately 10:40 a.m. revealed, Resident #3 was prescribed to receive 10mg of Regian (Metoclopramide HCL 5mg/5ml Solution) at noon Monday through Friday as written on the 10/2009 physician's orders. Interview with the qualified mental retardation professional (QMRP) on 11/3/2009 at approximately 2:07 p.m. revealed she was notified of the missed medication on 3/9/2009. She was not sure why it took the day program almost a month to notify her of the incident. But, the QMRP failed to notify the Department of Health of this medication error as well.

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	At the time of the si notified the Departr	urvey, the GHMRP henent of Health of this	ad not incident.			·	
I 401	Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure professional services were provided in accordance with the needs of two of the three residents in the sample. (Resident's #1 and #2) The findings include: A. The GHMRP failed to ensure preventive health services were coordinated for the completion of recommended diagnostic procedures for Residents #1 and #2 as evidence below:			ì 401			
[1. Client #2 received hematologoup (Copy attached) 2. Client #1 had a Prolactin le (copy attached)9-26-09. The level was high and the level but indicated that the issue unless she begins lact As indicated by the surveyor quarterly nursing physicals departure of one RN and the replace her. Quarterly nursic current for each person sup the future, the Director of N no such gap occurs by assig complete the task, using complete the task, using complete the task in task herself 12-30-09	PCP will mon current level is ating 12-14- or, a gap in cor was created by the time it took ing physicals a ported at this to the line ing another I insultants in the	itor the s not an 09. mpleting y the to re sume. In sure that RN to e
	1. The GHMRP failed to ensure that Resident #2 was received a hematology follow-up as prescribed. On 11/2/09 at 8:02 a.m., Resident #2 was administered Ferrous Sulfate 325 (65 mg) tablet. Interview with the medication nurse during this time revealed the resident received the medication to prevent a low iron level. Record verification on 11/3/09 at 9:05 a.m. confirmed that the resident had a physician's order to receive				Interviews with medication nurses incircatment was given but not properly (Hydrogen Peroxide to ears). The RN passing nursing to insure that they do medications and treatments consistent Additionally, the RN will audit the M weekly to insure the above 12-30-09	documented will train med cument all tly12-30-09 ARs at minim	

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J 4 01	Continued From pa	ige 12		I 401				
	times. Continued record review however revealed no laboratory reports of prolactin level were available.					·		
Interview with the primary R.N. on 11/4/09 at 9:30 a.m. evidence that no laboratory test to assess Prolactin values had been conducted.								
:	#1 and #2 received	GHMRP failed to ensure that Residents #2 received a physical examination by a ered Nurse at least quarterly as evidenced						
	p.m. revealed that group home on 8/1 R.N. revealed at th		it the w with the review of					
On 11/4/09 at 9:22 a.m., and 11:29 a.m. respectively, review of medical records of Residents #2 and #1 revealed that a six month period had elapsed between quarterly nursing assessments as follows: a. Resident #2 had a 2nd quarterly assessment on 4/3/09, then the next nursing quarterly was conducted on 10/7/09, 5 months later. b. Resident #1 had a 2nd quarterly assessment on 4/9/09, then next nursing quarterly assessment on 4/9/09, then next nursing quarterly assessment was conducted on 9/28/09, 5 months later. The R.N. acknowledged that there had been a break between the time the previous primary R.N. was transferred from the GHMRP and the time that she began working at the GHMRP. There								

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				A. BUILDI			(X3) DATE SURVEY COMPLETED	
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	was no evidence that each resident assessment at lea	hat the GHMRP had e received a physical ast quarterly.	ensure					
	C. The GHMRP fa was administered evidenced below:	illed to ensure that me without error for Resid	dication lent #2 as					
Interview with the primary R.N. on 11/3/09 at 2:18 p.m. revealed that Resident #2's treatment prescribed to prevent ear wax impaction was changed by the primary care physician in July 2009.								
	Mineral Oil 1/2/+ each ear 3 x a mon the medication addrevealed no docum (H2O2) + mineral of administered to the 2009. There was n	11/3/09 at 4:49 p.m. related 7/21/09 for H2O 1/2 in dropper bottle, 3 nth - each ear. The reministration record, ho nentation that the peropil drops had not been a resident on any day is evidence the GHMR nt's medication was put error.	3 gtt to view of wever, xide					
	1 1/OAISIONS				3520.4 The QMRP will insure that the comsideressed in the upcoming ISP meewill thereafter insure via monthly	munication issue is		
	Professional services shall include an annual health inventory of each resident.			t	will thereafter insure via monthly me hat follow up occurs in a timely ma see also responses for W249.	ung and thereafter a Onitoring and review nner 12-30-09,	und WS	
	review the Group H Person (GHMRP) for	met as evidenced by: on, staff interview and ome for the Mentally F alled to ensure that res Speech and Language f three sampled Resid	Retarded sidents		10(W249,			

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0236		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/04/2009		
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	HERAPEUTIC SERVI	CES, INC	927 55TH	STREET, N TON, DC 2	E				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORPRETIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)			SHOULD BE	(X5) COMPLETE DATE	
1 402	The finding included on 11/2/2009 between 6:50 p.m., Resin front of a small to to music from a small to music from a she was allowed to more music. She makes the survey teather the survey teather the survey teather the survey to assessment dated of following: 1. Continue building and expressive languages allowing recreational/social into 1 time allowing recreational/social into	een the hours of 3:30 ident #3 was observed be in the living room tall portable radio. Room this seat between to have dinner. After return to her chair to emained there until 6 am left the GHMRP. 1/3/3009 at approximal, Resident #3's Spectory. 1/4 Resident #3's Spectory. 1/5 Resident #3's Spectory. 1/6 Resident through the actions as well as esident to express here. 1/6 Indication skills and changes and adjust cessary. 1/6 Indication skills and changes and adjust cessary. 1/7 Indication skills and changes and adjust cessary. 1/8 Indication skills and changes and	ed sitting In listening esident 15:52 Ir dinner I listen to 5:50 p.m. Inately ech (SLP) ded the sceptive s using 1 erself. Inually to ation 50 p.m. rent updated	1 402					

C74R11

Health	Regulation Administr	ation				FORM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HF D03-0236		ER/CLIA IMBER;	(X2) MULTI A BUILDIN B. WING	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
NAME OF	PROVIDER OR SUPPLIER	111 003-0236	STREET AD	DRESS OF S	STATE, ZIP CODE	11/	04/2009
	HERAPEUTIC SERVI	CES, INC	927 55TH	STREET, NI STON, DC 20	Ė		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			JD PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO DEFICIENCY	(X5) COMPLETE DATE	
1 401	Continued From pa	ge 11		1401			1
	Ferrous Sulfate 325 (65 mg) tab TID on Monday trough Friday and BID on Saturday and Sundays for anemia.			1401			
	Interview with the principle of the province o	that Resident #2 was matologist. Record ogy consultation repowas noted that the re- nicrocytosis and sho linic in one year for for rivey, there was no elow-up appointment sident.	as being review ort dated esident uld return ollow-up, vidence had been				
1	On 11/2/09 at 8:30 a. administered Haldol at The resident lay on the bang her head as the medication nurse revolution of the medication nurse revolutions are revealed to manage subsequent record read in the properties of 7/7/08 at the properties of 7/7/0	o mg tab (3 tabs, 15 ne floor and attempte nurse verbally prome floor. Interview with ealed the Haldol was the resident's psychologiew on 11/2/09 at 9 nt physician's order, at daily in the morning daily in the morning	mg). ed to opted the shosis. 0:07 With an				
つ "! に R re	Record review on 11/4/11/09 Quarterly Pha Haidol - Needs Prolateview of the resident' eviews dated 11/25/6 evealed assessment rolactin level was als	rmacy Review which of the Control of	n stated ne cy 109				